Case History (Adult)

Patient #: _____

Foundation Chiropractic Center

895 State Farm Road Suite 401 Boone, NC 28607 828-865-6500

Name: _____ Date: _____ D.O.B.: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (Home): _____ Cell: _____ Work: _____
E-mail: _____
Occupation: _____ Employer: _____ Sex: M F Marital Status: S M D W
Spouse's Name: _____ Spouse's Phone: _____
Referred by: _____ How did you hear about us? _____
Emergency Contact: _____ Emergency Contact phone number: _____

PRIMARY REASON FOR CONSULTING OFFICE

Present complaint: _____
Pain/problem started on: _____ Have you experienced this before? **Y N** When? _____
How did your symptoms begin? (i.e. gradually, suddenly, etc.) _____
Is this due to an injury or accident? **Y N** Describe _____
Frequency of symptoms: ____ Daily ____ 2-3 times weekly ____ Sporadic Describe _____
How often do you experience your symptoms? ___ 0-25% of day ___ 26-50% of day ___ 51-75% of day ___ 76-100% of day
Pains are: ____ Sharp ____ Dull/Ache ____ Numbness ____ Shooting ____ Burning ____ Tingling
Pain intensity: ___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 0 = No pain 10 = Unbearable
Symptoms are better with: _____ Symptoms are worse with: _____
How are your symptoms changing? ____ Getting better ____ Not changing ____ Getting worse _____
Is this condition worse at certain parts of the day? ____ Morning ____ Afternoon ____ Evening ____ During sleep
Are you currently or have you seen a doctor or chiropractor for this condition? **Y N**
Dr./Office name: _____ When? _____ What were the results? _____

PLEASE MARK AN (X) IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING IN THE PAST YEAR:

General
_____ Fatigue
_____ Fever
_____ Weight gain > 10 pounds
_____ Weight loss > 10 pounds

Respiratory
_____ Chronic cough
_____ Decreased exercise tolerance
_____ Difficulty breathing
_____ Coughing up blood
_____ Sputum production
_____ Wheezing
_____ Asthma
_____ COPD

Cardiovascular
_____ Chest pain
_____ Leg pains with walking
_____ Leg swelling
_____ Palpitations
_____ Heart disease

Musculoskeletal
_____ Decreased range of motion
_____ Joint pain
_____ Joint redness
_____ Joint swelling
_____ Joint stiffness
_____ Muscle weakness
_____ Muscle aches / pains

Neurological
_____ Loss of bowel / bladder control
_____ Dizziness / vertigo
_____ Headaches
_____ Numbness / tingling
_____ Passing out
_____ Seizures
_____ Tremor

Psychiatric
_____ Anxiety
_____ Change in sleep pattern
_____ Depression
_____ Hallucinations
_____ Suicidal thoughts

HEENT
_____ Blurred vision
_____ Eye pain
_____ Eye redness
_____ Decreased hearing
_____ Earache / infections
_____ Ear ringing
_____ Nose bleeds
_____ Dry mouth
_____ Sore throat
_____ Sinus problems
_____ Allergies

Other
_____ Constipation
_____ Diarrhea
_____ Nausea
_____ Urinary problems
_____ Menstrual irregularities
_____ _____
_____ _____
_____ _____

Turn Over (To complete back) ------->>

Are you or is there a chance you may be pregnant? **Y N**

OPERATIONS AND PROCEDURES

Please mark an (X) next to the appropriate procedures and write an approximate date

____ Neck surgery _____	____ Back surgery _____	____ Hernia _____
____ Gall bladder _____	____ Appendectomy _____	____ Sinus _____
____ Tonsillectomy _____	____ Tubes in ears _____	____ Thyroid _____
____ Reproductive organs _____	____ Rectal surgery _____	____ Stomach _____
____ Other: _____	____ Other: _____	____ Other: _____

Do you use tobacco products? **Y N** Packs/day: _____
Do you consume alcoholic beverages? **Y N** Drinks/day: _____
Do you consume caffeinated beverages? **Y N** What: _____ Cups or cans/day: _____
Exercise: ____ None ____ Moderate ____ Daily Describe _____
Average stress level: __ 0 __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 0 = No stress 10 = Max stress
Do you eat a diet high in fruits, vegetables, and whole grains? **Y N**
Do you eat a diet high in fat? **Y N** High in sugar? **Y N** High in salt? **Y N**
How many meals do you eat per day on average? _____
How many glasses of water do you consume per day? _____
Are you currently taking any **vitamins, minerals, or supplements**? **Y N** Please list: _____
_____
Are you currently taking any **over-the-counter medications**? **Y N** Please list: _____
_____
Are you currently taking any **prescription medications**? **Y N** Please list: _____
_____
Are there any other health-related issues that need to be mentioned before beginning care? **Y N** Please describe: _____
_____
Are there any other topics you would like to discuss? **Y N** Please describe: _____
_____

Patient's/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____